THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-5800.M5

MDR Tracking Number: M5-04-0424-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-10-03.

The IRO reviewed therapeutic exercises, office visits/outpatient, joint mobilization, myofascial release, manual traction therapy, ROM measurements and muscle testing rendered from 04-23-03 through 07-16-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The therapeutic exercises, office visits/outpatient, joint mobilization, myofascial release, manual traction therapy and ROM measurements for dates of service 04-23-03 through 06-12-03 were found to be medically necessary. The therapeutic exercises, office visits/outpatient, joint mobilization, myofascial release, manual traction therapy and muscle testing for dates of service 06-16-03 through 07-16-03 were not found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-17-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
4-23-03 through 5-6-03 (5 DOS)	97265	$215.00 ($43.00 per unit X 5 DOS)	$0.00	G	$43.00	96 MFG MEDICINE GR (I)(9)(c)(10)(a)	Not global to any other service billed on dates of service. Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		$215.00	$0.00				The requestor is not entitled to reimbursement.

This Decision is hereby issued this 16th day of April 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 04-23-03 through 07-16-03 in this dispute.

This Order is hereby issued this 16th day of April 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

December 16, 2003

MDR #: M5-04-0424-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:
The patient was injured on-the-job on ___. He felt a pop in his neck and had neck pain which radiated between his shoulders, primarily to the left shoulder. An aggressive treatment program was begun, utilizing chiropractic care and passive and active therapy. Over the course of treatment, the patient also received epidural steroid injections, was treated with anti-inflammatory medications, muscle relaxants, and pain medication.

A report dated 09/25/03 indicated that none of the treatment has helped him so far. On a Visual Analog Pain Scale, he rates his neck pain as an 8 on a scale from 1 to 10, and his arm pain a 7.

Diagnostic testing in the form of an MRI revealed a suspected 3.0 mm disk protrusion. However, there is a discrepancy as to the quality of this MRI, and a recommendation for a repeat MRI was made.

Disputed Services:
Therapeutic exercises, office visits/outpatient, joint mobilization, myofascial release, manual traction therapy, ROM measurements, and MT muscle testing for dates of service from 04/23/03 through 07/16/03.

Decision:
The reviewer partially agrees with the determination of the insurance carrier. The services in question **were medically necessary** from 04/23/03 through 06/12/03. After 06/12/03 the services **were not medically necessary.**

Rationale:
The records indicate the patient underwent an aggressive passive and active therapy and rehabilitation program. National Treatment Guidelines allow for this type of treatment for injuries of this nature. However, there are no National Treatment Guidelines that allow for the intensive treatment program this patient received. Normal treatment guidelines allow for up to two to four weeks of passive therapy with a progression into an active therapeutic rehabilitation program for six to eight weeks. This patient's treatment program exceeded the normal recommended National Treatment Guidelines.

Therefore, all treatment in the form of therapeutic exercise, office visits/outpatient, joint mobilization, myofascial release, manual traction therapy, ROM measurements, and MT muscle testing up to and including date of service of 06/12/03 was, in fact, reasonable, usual, customary and medically necessary for the treatment of this patient's injury. However all treatment which included therapeutic exercises, office visits/outpatient, joint mobilization, myofascial release, manual traction, ROM measurements, and MT muscle testing after 06/12/03 was NOT medically necessary for the treatment of this patient's injury.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,